DOCUMENT RESUME

ED 166 923 EC 113 840

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TITLE Training the Developmentally Disabled for Community Living: A Community Effort.
PUB DATE 78
NOTE 15p.; Paper presented at the Annual Convention of the Midwest Association for Behavior Analysis (4th, Chicago, Illinois, May 13-16, 1978); Part of a symposium "Training the Developmentally Disabled for Community Living" ; Not available in hard copy due to print quality

EDRS PRICE MF-$0.83 Plus Postage. HC Not Available from EDRS.
DESCRIPTORS *Adjustment (to Environment); Behavior Change; Community Programs; *Developmental Disabilities; Intervention; Normalization (Handicapped); *Program Descriptions

ABSTRACT

The paper reports on a Stockton, California, program to train developmentally disabled children for community living. Evaluation and referral procedures are discussed, as are financial statistics. Treatment results are summarized and the example is given of successful intervention with a 13-year-old multiply handicapped boy with untrained bowel habits. (CL)

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Training the Developmentally Disabled for Community Living: A Community Effort[1]

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[1]This paper was presented by John R. Lutzker as a part of a symposium, "Training the developmentally disabled for community living," (A. J. Cuvo, Chair) at the fourth annual convention of the Midwest Association for Behavior Analysis, Chicago, Illinois, May 13-16, 1978.

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Training the Developmentally Disabled for Community Living: A Community Effort

In California, as in the rest of the nation, we have been charged with the task of deinstitutionalization. Like so many other places, the goals seemed fine, but the way to reach them seemed unclear. However, if a group of people who have common goals can gather together, something productive is usually accomplished. I believe that in providing service to developmentally disabled persons that the best service is usually provided when both selfless and selfish needs are served. The selfless aspects are obvious, a sincere concern for the welfare and habilitation of others. The selfish aspects usually involve issues such as the need to support and train students, the need to be seen as innovative as an agency, faculty member, or administrator, and other reasons. Three agencies in Stockton share these common needs. The undergraduate and graduate programs in Applied Behavior Analysis need to provide support and training for the students, the State Hospital needs to attempt to carry out the charge for deinstitutionalization, and the Regional Center needs to demonstrate that it is providing service to its clients. So, three years ago John Mabry and Santi Rogers from Stockton State Hospital, Jim Austin from Valley Mountain Regional Center, and I (representing the University of the Pacific) wrote a grant aimed at the deinstitutionalization of the Child Development program at the hospital. We felt that three components were necessary in preparing the children for community living. Thus, we called the grant Phase 3. The first phase involved training the children in basic self-help and self-amusement skills. We did this by creating and testing, or modifying existing, task analyses for skills such as toileting, grooming, dressing, and so on. Students from Pacific represented the bulk

of our trainers. Within nine months most of the children on the Program had been through several or all of the self-help training packages. Self-amusement training was developed and researched under a logic that many developmentally disabled children become burdens to their parents and care providers because of an inability to spend idle time in anything but autistic-like behavior. Thus, we developed task analyses for cooperative play, including a rather novel one for teaching basketball using graduated basket height, and self-play with "Lincoln Logs" or blocks. The self-play with blocks was presented at APA in 1976 and Dennis Raschke, a graduate student of mine, recently completed a thesis in further pursuit of promoting self-play in severely delayed children.

The second phase involved training the direct care providers in the hospital to use our training packages and training the parents and community care providers to use our training packages. This was done using a competency-based training package that began at the hospital with paper and pencil work, then modeling and role-playing, then gradually faded "hands-on" training and supervision while working with children on the unit other than the parent or prospective care provider's own child, then their training of the child targeted for home placement, and finally home training and supervision. The third phase was supposed to involve us operating a sort of "behavior mod squad" aimed at keeping newly placed children in the community by remediating any new behavior problems. However, we had made an unusual error. The grant was originally supposed to be a three-year project with each phase taking about a year. But we had accomplished the goals of the first two phases in slightly over a year, so for some still confusing to me bureaucratic reasons, we were not funded for our last year and a half. This, however, turned out to be a "blessing in disguise." We decided that to maintain the community

as toileting or eating problems to severe, sometimes life endangering, behaviors such as self-abuse.

2. The client's case manager then completes a Functional Analysis Interview form. This form is designed to obtain, either from the client or an appropriate informant, information regarding the specific description of the problem behavior, the antecedent events to the problem behavior, the consequences for the problem behavior, the previous attempts, if any, to modify the problem behavior, the rate of the problem behavior. The case managers were trained to perform these initial assessments via role play and modeling.
3. The case manager then completes a "Critical Need" assessment. This form will place the case into one of three levels according to how critical it is that B.I.S. training begin. The first critical need level is for clients who are in danger of being placed, because of inappropriate behavior, into more restrictive environments. This could mean that a client would be taken from his natural home and placed into a care home or possibly from a care home into a State hospital. This also could refer to a client's losing a placement in some type of educational setting. The second critical need level is for those clients who are in need of training, however, the presenting problem is still "tolerable" by those closest to the client. The third critical need level is for clients who have problems that are mostly cosmetic in nature, i.e., the problem may inhibit a client's social integration somewhat but would not endanger a client's home or school placement. As one may perceive an interesting aspect of the critical need assessment is that frequently assignment to one of the three levels is based on socio-

placements that we had made and to provide a prevention service to other children who might be considered for the institution, trying to find "hard" rather than "soft" money sources would be more useful on a long-term basis. Jim Austin and Jerry Goff, from the Regional Center, went to Sacramento and knocked on doors until they got the answer we wanted which was the state's approval for a unique direct treatment service which would be provided to developmentally disabled children and their families in homes, schools, care-homes, and rehabilitation settings. We did not want the service hidden under some rubric such as respite care or developmental specialist, we wanted it over the table as direct behavior modification. We named it Behavioral Intervention Service or B.I.S. I was approved under our job descriptions as Chief Behavioral Consultant and we created two trainer levels known as Behavior Analysts I and II. The money to fund B.I.S. comes out of the state's purchase of service funds which are the major resources for the regional centers. Catholic Charities of Stockton, an already vendorized service provider, agreed to handle our overhead and insurance. This has been a special advantage because we are then not bogged down by administrative details and can thus fulfill our charge of direct service. Naturally, our local regional center, Valley Mountain Regional Center, has sought our help the most; however, three bay area regional centers and the North Coast Regional Center have also used our service.

At this point, let me review for you our evaluation and referral procedures. The Behavioral Intervention Service receives referrals from the Center following:

1. A case manager, teacher, or parent identifies a problem behavior that is inhibiting a client's social, intellectual, or vocational growth. These problems range from simple skill acquisitions such

logical factors rather than psychological ones, e.g., to some parents thumb sucking in a 10-year-old child is an intolerable problem while other parents have lived with much more severe problems for years.

4. Once this process is completed the case manager forwards the forms to a liaison. The liaison then decides on the basis of time the case would require, c.ltical need, and available resources whether to send the case on to B.I.S. or to retain it for parent training.
5. When B.I.S. receives a case, we assess it in terms of the estimated number of hours the case would require to complete and send the estimate back to the regional center.
6. The required hours are reviewed by a Purchase of Service Committee, and if approved, are purchased at the rate of $9.50 per hour. Training can then begin.
7. After service has been completed, a consumer evaluation is provided for each capable recipient of B.I.S. service, such as parents, teachers, aides, staff, siblings, and sometimes the clients themselves.

Out of the $9.50 per hour our behavior analysts are paid $5.72, I was paid 80¢, $1.00 goes to travel, and the rest is for Catholic Charities' overhead. This has provided a unique reciprocal service. It provides successful treatment and training for our developmentally disabled clients, it provides a professional wage and training for our behavior analysts, and the regional centers and Catholic Charities can feel that they are fulfilling their responsibilities as service providers. In fact, B.I.S. recently received an award for innovative services from the California Commission on Developmental Services.

As of April, we had served 32 clients. With each client, we averaged 52 hours or $494.00. The projected budget for B.I.S. for V.M.R.C. for next year is $44,000 serving 75 clients, more than we served on the grant for less cost.

Let me briefly summarize[3] some of our treatment results. Probably our most notable successes have come with toilet training. Our first case provides a good example of the utility of B.I.S.

Billy was a 13-year-old male who was deaf, had cerebral palsy, and was diagnosed as severely retarded. He demonstrated considerable receptive and some expressive sign language. One of the two Behavior Analysts assigned to the case possessed signing skills. Billy lived at home in Stockton on weekends and during the summer and attended a residential school for the deaf 90 miles from Stockton during weekdays of the school year. Despite being bladder trained since childhood, Billy had never made a correct bowel response in the toilet. He usually had two temporally predictable bowel accidents per day, one in his pants in the afternoon and one in bed shortly after retiring except for a period of time just prior to behavioral intervention when he was "hoarding" for up to two weeks at a time as an apparent result of a distended colon. The "hoarding" and distended colon were treated medically just prior to behavioral intervention. The case was considered crisis because Billy was threatened with expulsion from the school since there was a rule that all residents 13 years and older must be fully toilet trained. The study took place at the end of summer just prior to Billy's return to school.

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[3]These studies were presented verbally in greater detail at the convention.

A modified Azrin and Foxx (1974) procedure was used to teach bowel responding. Billy was required to sit on the toilet every 15 minutes during times known to be "accident" times. Modeling was done with doll play as described by Azrin and Foxx (1974) with a redwood chip used as symbolic fecal matter. Training with the Behavior Analysts occurred in the home during four sessions which included training the mother in the reinforcement and positive practice procedures.

Figure 1 shows that Billy made his first correct bowel response in his life in the toilet on the second day of intervention. His first errorless day was on the fourth day of intervention. No accidents occurred after the 13th day of intervention. Generalization occurred at the school where he began a few days after the beginning of the semester. The Behavior Analyst accompanied him on his return to school, reminded him where the toilet was, asked him where he was going to make bowel movements, and trained the staff in the intervention procedures. Billy immediately began making correct responses at school and has never again had an accident.

Other cases that B.I.S. has tackled have included the modification of sexually assaultive and abusive behavior (Polvinale, deLongpre, & Lutzker, Note 1), self-feeding training, the modification of hyperactive-stereotypic behavior, and self-injury.

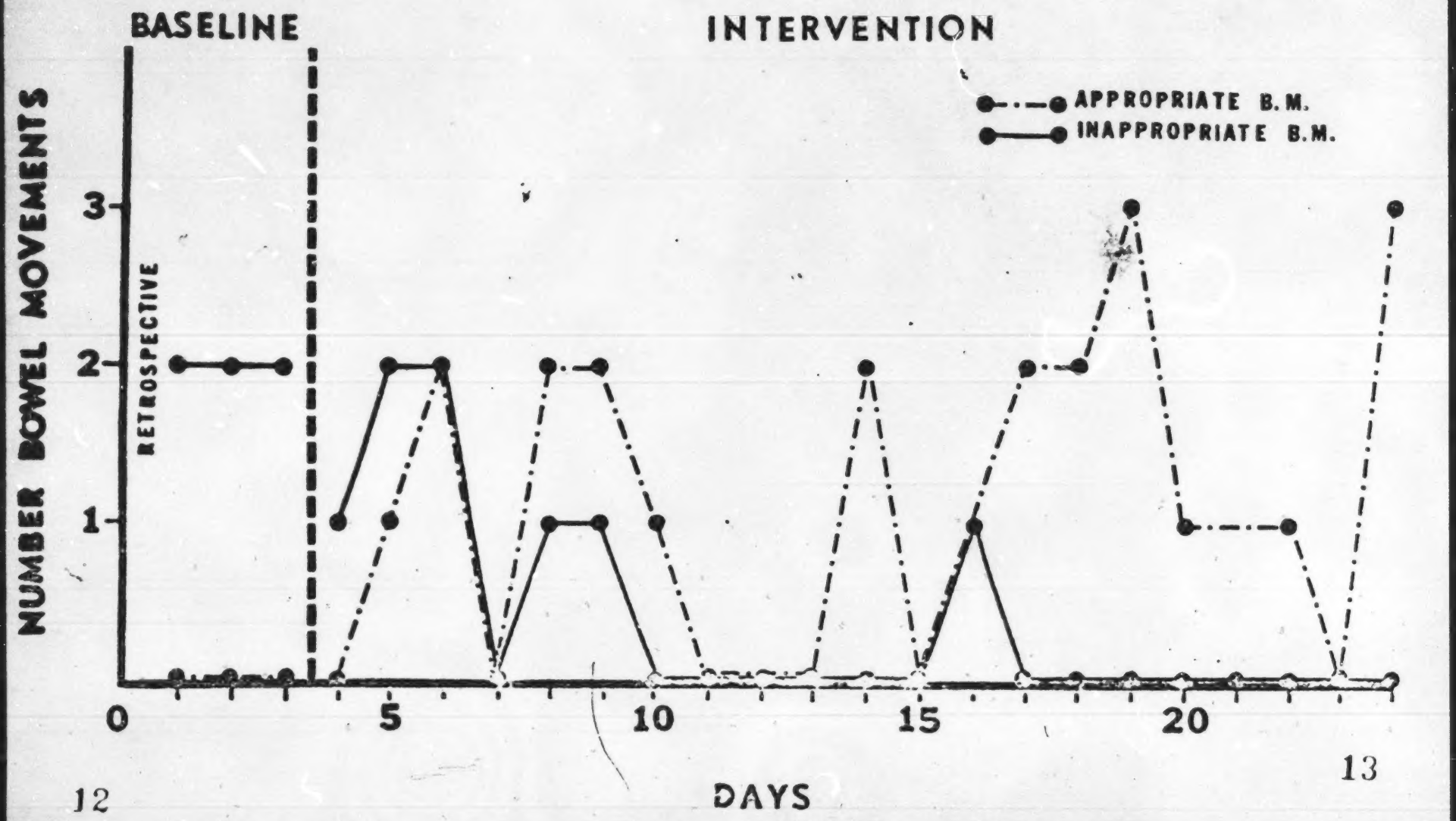
In summary, our community living programs in the Stockton area have truly been a community effort and we are pleased at being able to feel that we are providing a community service.

Reference

Azrin, N. H., & Foxx, R. M. Toilet training in less than a day. New York: Simon and Schuster, 1974.

Reference Note

1. Polvinale, R. A., deLongpre, J., & Lutzker, J. R. Reduction of assaultive and inappropriate sexual behavior through the use of positive reinforcement and social-restitution procedures. A poster presented at the fourth annual convention of the Midwest Association for Behavior Analysis, Chicago, Illinois, May 13-16, 1978.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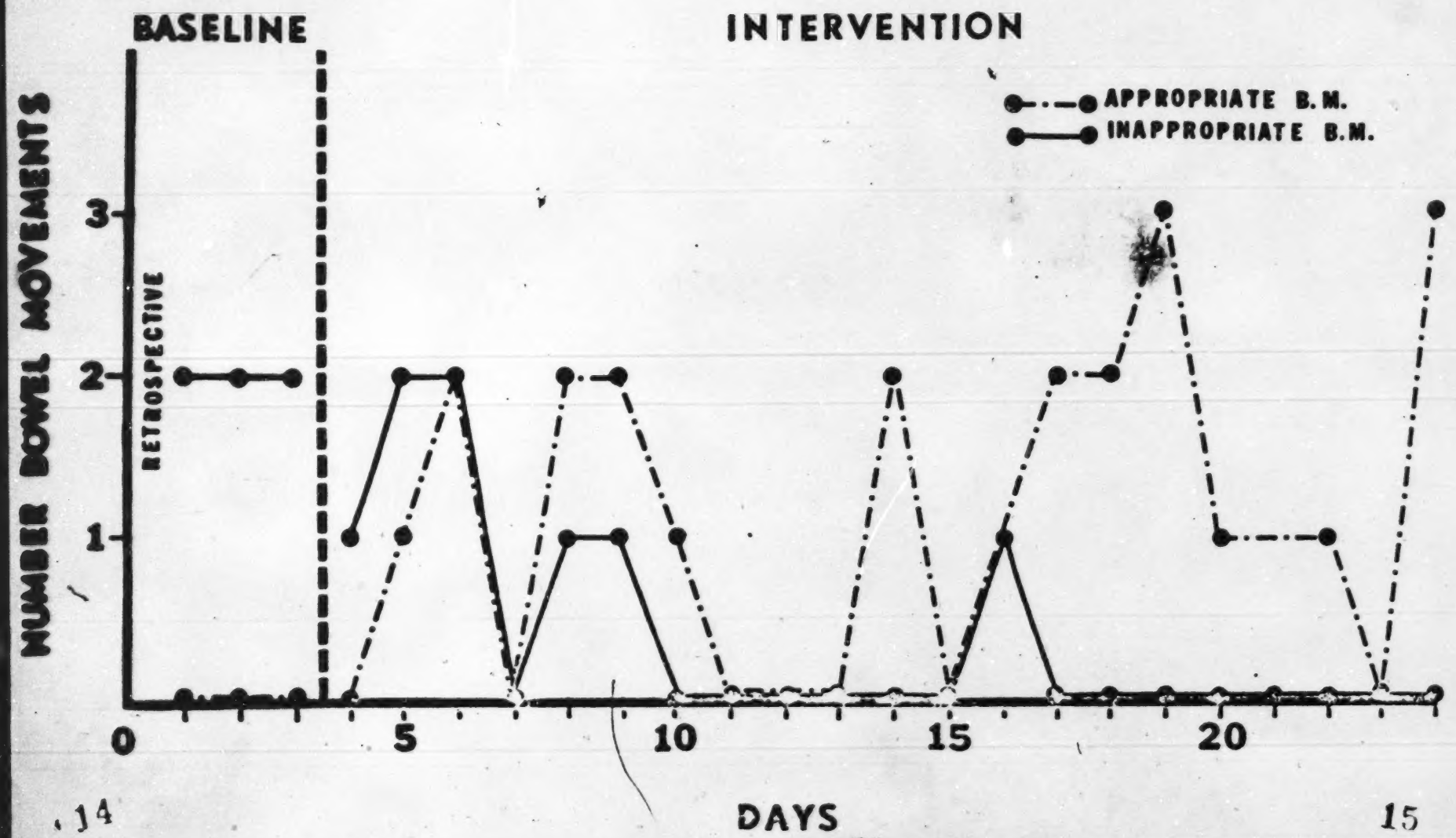
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